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THE MEDICAL FORUM

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No. 3.

ORIGINAL ARTICLES.

INTESTINAL OBSTRUCTION.*

BY W. J. GATES, M.D., KANSAS CITY, MO.

Professor of Surgery, Kansas City Hahnemann Medical College.

Obstruction of the intestine is of more or less frequent occurrence, and due to widely varying causes; among the more common forms we have, in the order named: fecal impaction, volvulus intussusception, peritoneal bands, neoplasms, gallstones, cicatricial contractions, spasmodic iliac and strangulated hernia.

The symptoms in all of the different forms are practically the same, excepting that in fecal impaction we may get frequent desire to stool, each stool consisting of a small amount of fecal matter and being accompanied by considerable straining.

The impaction is frequently in the sigmoid flexure, and may be detected by digital examination through the rectum.

In intussusception there is constant desire to stool, great tenesmus and discharge of bloody mucus.

The other varieties are marked by obstinate constipation and entire absence of passage of flatus per rectum. Vomiting usually comes on suddenly and is generally continuous. Marked pain, usually over the site of obstruction, is present. The temperature at first is but slightly, if any, disturbed; later becoming elevated, due to auto-intoxication. Within a short time the abdomen becomes distended by gas and tympanitic.

*Read before the Kansas City Homeopathic Medical Society, January, 1907.

The peristaltic action of the bowel above the site of obstruction is increased. Respiration is accelerated and supracostal; frequently the diaphragm is fixed spasmodically and hiccoughing may be present.

In spasmodic ileus, to which I would especially refer this evening, the pain is remittent, the aggravations often occurring with clock-like regularity.

The symptoms are caused by a spasmodic contraction of the intestine, usually the ileum. The contraction may narrow the external diameter as small as three-eighths of an inch and involve from a few inches to several feet of the intestine. It is probably due to some reflex irritation acting upon the sympathetic nervous system.

From among a number of cases of obstruction, occurring in my practice, I have selected three as illustrative of this form.

Case I.—Mrs. F——, married, aged 32. Nervous temperament, general health fair. First complained of pain about the diaphragm, with inability to take a long breath. Respiration quite shallow and rapid. In spite of all treatment, her condition grew rapidly worse; it was decided to operate. This was done by Dr. Forster. The only abnormal condition found was a tense contraction of the ileum a few inches in length. The contracted bowel was withdrawn from the abdomen and wrapped in hot towels, where it quickly relaxed. Irregular breathing had continued under the anesthetic, but was instantly and completely relieved at the moment of relaxation of the intestine. The abdomen was closed, and when the patient recovered from the anesthetic, she was apparently free from all symptoms of obstruction. Seemed to be doing well for several hours. She was suddenly seized with a faint feeling, and died quite suddenly ten hours after the operation.

Case II.—Mr. S—— came to my office complaining of frequent desire to micturate. Shortly after leaving the office the patient passed a large quantity of bloody urine. I then learned that he had been using a grain-tester in sampling cars, and that the tester had been pushed into the grain by placing the handle against the right inguinal region and throwing the weight of the body against it. The urine soon became free from blood, but tenderness began to be apparent along the right spermatic cord and the right testicle began to swell. The patient

was placed in bed, and at the end of several days seemed to be improving; the testicle, however, remained indurated. About the seventh day I was called to see the patient, and found him suffering with severe pain in the region of the umbilicus. Constipation was complete, and vomiting at intervals of from two to three hours. Repeated efforts were made to move the bowels by enema of various sorts and by administration of calomel, castor oil and Rochelle salts per mouth. No results whatever. The next day the patient was removed to the hospital, where I made a laparotomy. Immediately below the umbilicus a contraction of about three feet of the small intestine was encountered. Upon being withdrawn from the abdomen and placed in hot towels, the bowel quickly relaxed. No other evidence of obstruction was found. After being returned to bed, the patient slept several hours and awakened entirely free from pain.

Previous to operation, 1-2 grain of morphine with 1-150 grain of atropine had failed to give any material relief from pain. In about a week the testicle suppurated, and I found it necessary to remove the same. The patient made complete recovery, and has since been well.

Case III.—Mr. H—— came to me with a history of intermittent attacks of intestinal obstruction, accompanied by attacks of severe pain, intermittent in character, extending over a period of five years. An incision was made into the abdomen over the region of the pain, and the cause of the trouble sought. Several feet of the small intestine were found to be contracted, and the omentum and mesentery were found to be full of enlarged glands. The bowel, being laid in hot towels, soon relaxed and assumed a normal size and color. Some of the glands were removed, and found by the pathologist to be tubercular. No bands or adhesions were found. The patient was quite fleshy and a troublecome stitch abscess occurred in the superficial fascia, from which the patient suffered severely. After recovery, the pain, which had been present more or less constantly for five years, had entirely disappeared, and has not since been present.

Intestinal obstruction should be treated vigorously and without delay. Among the useful enemata are the following: Turpentine, 1 ounce; white of 1 egg; place in pint bottle and shake until thoroughly mixed; then add 1 pint of lukewarm water; to

be given with a colon tube. A pint of linseed oil, given in similar manner, followed in half an hour by a soapsuds enema. Pulverized ox-gall, 2 drams; water, 2 pints; given by a colon tube.

If caused by fecal impaction, an anesthetic may be given and the impaction removed through a speculum. A hypodermic injection of 1-100 grain of atropia has served to relieve. As a rule, cathartics per mouth only serve to aggravate the vomiting. They should, however, be tried. Among the most useful are: Elaterin, 1-6 grain; every hour until bowels move or nine have been taken. Calomel and soda, 1-4 grain; repeated every hour up to 2 grains. Castor oil, 1 ounce; Rochelle salts, saturated solution, 2 drams; every hour until bowels move. Intoxication appears early and shock is usually well marked and rapidly increasing in severity. If at the end of six hours success has not been attained, I should advise surgical interference. If aseptically done and with proper technic, exploratory incision is absolutely devoid of danger, while the prospects of relief for the patient in obstructions due to causes other than neoplasms is always good.

THE FALLOPIAN TUBE AND ITS PERITONEAL ADHESIONS.

BY J. L. ALEXANDER, M.D., KANSAS CITY, MO.

Professor of Surgery, Kansas City Hahnemann Medical College.

It is only within comparatively recent times that pathology in the Fallopian tube has been recognized, or its connection with plevic pathology appreciated. With all we have learned of these conditions in the past few years, it remains, as yet, for someone to propose the means of preventing peritoneal adhesions. The story is a long one, that tells of damaged uterine appendages; so we will not go so much into detail, as to structural alterations, but refer more especially to their functional activity. It is not the intention here to treat of diseases dependent upon the uterus, such as tumors, or of neurotic conditions induced by and under the control of the reproductive organs. It is therefore the function of the organ we desire to control, not an organ necessarily diseased that we aim to cure.

I believe I am safe within the limit when I say that 60 per cent of the infectious diseases of the tube are gonorrheal

in origin. From a clinical standpoint, acute salpingitis is seldom recognized. This is not because the condition does not exist, but because in its early stage it presents no symptoms beyond those common to the pre-existing disorder of the uterus. In the common forms of endometritis, the disease is subacute, of slow progress, and until the later stages, the interstitial portion of the tube alone is affected. In puerperal cases due to the streptococcus, the tubal disease is only a part of the general pelvic infection, and can hardly be described as a distinct infection. The gonorrheal endo-salpingitis is occasionally recognized, and then only when the march of the disease has been so rapid that the pelvic peritoneum is invaded before the closure of the abdominal end of the tube has occurred. This class of cases demands immediate operation.

Generally speaking, the salpingitis that results in adhesions is practically a chronic disease. Its march is slow and is preceded or accompanied by closure of abdominal end, by coaptation of its walls or adhesions to the adjoining peritoneum. Later the uterine end of the tube becomes occluded and only discharges at intervals when the pressure by distention becomes too great. If a large rupture occurs in the tube wall, it is liable to result in diffuse peritonitis and death. If, however, the leak is slight, it is attended by a sharp attack of pelvic peritonitis. When the case has reached the stage of diagnosis—that is, when we can say with assurance that the tube is diseased and unable to perform its function, the pathology is by this time associated with adhesions, with other organs more or less extensive. These adhesions are of no regular form. They have appeared through the effort of Nature to restrict or localize the infection. A plastic exudate that walls off the local condition. Thus it may result in the sacrifice of a part for the safety of the whole. The force of the disease is spent and may be active only within the limiting wall. In chronic salpingitis it is almost impossible to find the germs which produced the disease, while in acute they may be easily demonstrated. These micro-organisms have disappeared and the pus is no longer infectious. It is said that the bacteria die from the accumulations of their own products. In this condition we have no more to fear from pus, but we have the tube surrounded and bound by adhesive bands, constricted, bent upon

itself and unable to functionate, even though its mucosa had not been destroyed beyond repair.

I have not been able to trace any constant relation between the extent of the adhesions and the degree of suffering that exists. As a rule, the density of adhesions goes hand in hand with the objective symptoms, but I have known it to be otherwise. A tube but slightly adhesive has been the seat of most intense pain, and *vice versa*. Along with this condition go several interesting clinical facts: The pain is not always constant with the side where the lesion exists. A like sympathetic reflex as exists between the ovaries.

In the majority of cases where adhesions of the tube are extensive and dense a cystic condition of the ovary will also be found to exist. The pain here will be of a reflex character, seeming to come from any organ in the abdomen.

The symptoms in this condition are not clear or distinctive, as in the acute condition they are veiled by the more severe uterine, and later in the chronic they become lost in the severe symptoms of a restricted and contracted ovary. Irritability, apprehensiveness, hysteria, and other psychic disturbances are the more common symptoms.

Then again we have the class of adhesions left from operative procedure about these organs. Wherever raw surfaces, pedicles, etc., are covered with peritoneum, the adhesive process takes place and finally results in restrictive bands, the same as in localized septic peritonitis.

The diagnosis can only be arrived at by the bimanual examination. As the adhesions gradually strengthen the tube becomes infiltrated and hardened, and is easily outlined between the uterus and the ovary. Usually it is convoluted or massed together and might be mistaken for the ovary. The tube and ovary are highly sensitive to touch. Both appendages may be affected, menstruation is painful, and if both tubes are implicated, the patient is sterile.

Our authorities tell us that the treatment of these adhesions falls in three divisions:

1. With medicine (including local treatment).
2. With electricity.
3. By laparotomy.

When I consider the method of development of these struct-

ures, and the purpose of their existence, I feel little confidence in the power of medicine to absorb or break up these bands. Internal medication may, by its influence upon the circulation, reduce the congestion and in this manner hold the condition in abeyance. I maintain then that we are wasting valuable time when we allow ourselves to be led into this method of treatment.

Electricity in competent hands has done good in a certain class of uterine adhesions, but I have seen cases that I know were aggravated by the use of electricity. The condition is palliated for a short time and many of the disagreeable symptoms disappear, only to reappear with the discontinuance of the treatment.

This condition is distinctly surgical and is safely removed by the hand of those familiar with abdominal work. The failures from this method arise from faulty technique and lack of thoroughness. The abdomen is opened by the usual method with incision large enough to admit of thorough exploration of the pelvis. Grasp the fundus of the uterus between the thumb and fingers, then follow out the course of the tube, bringing it into the wound if possible. The bands of adhesion are readily broken down with the finger, being careful not to tear away the covering of the tube.

Experience in such cases is the guide. If they cannot be broken down without injury to the adjacent parts, they should be severed with the scissors. Peritoneal surfaces that are lacerated should be promptly brought together and stitched with fine catgut. If adherent omentum is found, it should be gently sponged off from its attachments. A tube, even though imbedded in apparently inseparable adhesions, may often be shelled out with relative ease if the weaker lines of cleavage can be found and made the starting-points. The fingers search for sulci between the adherent surfaces. Look for the points of least resistance, and follow their lead so long as the separation does not require undue force; pressing and pinching until the outlines of the organs are clear.

As each adhesion is brought into view the part should be isolated by sterile pads, and, as the attachment is broken down, a small quantity of 50 per cent solution of peroxide hydrogen dropped upon the severed portion. In infective cases a small amount of pus will usually be found under the bands. The per-

oxide serves a double purpose in being thus exhibited: first, in the searching and destroying of pus; second, in controlling the oozing of blood when extensive surfaces have been removed.

After the peroxide has been thoroughly applied, the abdominal cavity is flushed with a normal solution and then closed in the usual way.

The use of Cargile's membrane has only been successful, with me, where it is buried in tissues.

Lately I have seen demonstrated the use of sterilized aristol. Dusted over the raw surfaces, it quickly forms a film, which is claimed by advocates of the method, to last from six months to one year. In Dr. Morris' clinic in New York, I have seen aristol used lavishly within the abdomen and without any bad results.

If this film lasts until these raw surfaces have healed, it certainly is a boon to the surgical world.

In closing, I wish to call your attention to the fact that after operations, adhesion can be prevented by covering all cut or raw surfaces with peritoneum, making no stumps unless absolutely necessary and not putting these delicate membranes on a stretch. A great deal of good surgery is spoiled by tying sutures too tightly.

GELSEMINUM; A STUDY.

BY CHAS. OTT, M.D., KANSAS CITY, KAS.

This paper is not written to recite the symptomatology and finer differential shades of the remedy. These can be found in any *Materia Medica*. Rather than this, we would give some general characteristics of gelseminum, which, though not on the list of the original polychrests, is more useful than the most of those so named.

The yellow jessamine or wild woodbine is a native of the more southern portion of our country, growing in swamps and woods and thickets. It is a handsome climber, reaching a length of from twenty to fifty feet. It bears early in the spring its flowers, which are "overpoweringly fragrant." The earliest description of it may be that which is found in Elliott's *Botany of South Carolina and Georgia* (1821).

Some time later it became known as a plant having medicinal virtues. Some enterprising doctor prepared an "electrical febrifuge," chiefly from this plant.

In the year 1860 it gained admittance, as an officinal remedy, into the United States Pharmacopeia. At first it was used by the eclectics and homeopaths, but now even the "regular" school employs it very frequently.

The best preparations of gelseminum are made from the fresh root. The common fluid extract made from the dry roots is not as reliable as the fresh plant preparation. The gelsemic acid gives it a bluish fluorescence so characteristic of this remedy. The very poisonous alkaloid, gelsemine, and the concentration, gelsemin, are regarded as available therapeutic agents.

Physiologic, or, rather, toxic doses show the remedy to be one of cerebro-spinal activity. It paralyzes the cerebro-spinal centers, abolishing first motility, then sensibility. Consciousness is retained till very late in cases of poisoning. One of the earliest symptoms is vertigo, made worse by standing or walking. The patient staggers, can hardly stand, much less walk. Diplopia and incoördination, pain in head, over eyes, complete this part of the picture.

When given to healthy persons, there is not much change in temperature; but if given in disease, there will be a reduction. If the dose is continued, we may expect paralysis of respiratory and cardiac centers, leading to death.

This same tendency to produce relaxation and even paralysis is manifest in its effect on the muscular and nervous centers in other parts of the body. Impotence and emissions will occur. In the female organs it produces congestion of uterus, spasmodic and neuralgic pains. Cramps will be felt in uterus, and even legs.

In order to have gelseminum indicated, we must have a nerve tension somewhere. As a consequence of this, we have irritation, increased blood supply, which may only be local. The condition for which it is suited is never one of asthenia. As a result of this hyperemia, we often have muscular twitchings or even distinct spasms.

Burt says: "This remedy is especially adapted to nervous, excitable, hysterical females, sensitive people and little children,

to male and female Onanists, and to malarial diseases." It is not a remedy for inflammatory diseases.

It is a useful remedy in headache. Hale says: "The typical headache may come on suddenly, with dimness of sight or double vision; vertigo; great heaviness of the head; it feels too big, and often too light; semi-stupor; heavy expression, full pulse and general malaise."

Lilienthal says: "Gelseminum stands foremost where symptoms of depression from heat show themselves; vertigo, dilatation of pupils, dullness of sight and a dull, confused headache spreading from the occiput over the whole head; no thirst, no appetite; feels completely played out." This is a valuable remedy in ptosis and diplopia.

Often we are requested to treat neuralgia or toothache and cannot find any special indications. A dose or two of gelseminum often relieves or clears up the case.

Remember gelseminum in catarrhal conditions. In the first stages of la grippe, common colds or catarrhal fevers few, if any, remedies can be found that are equal to this. "It is all the better indicated in catarrhal difficulties if motor disturbances occur, such as spasms of the larynx, pharynx and glottis, or so-called spasmodic asthma." (Hale.)

When exciting emotions are followed by large quantities of limpid urine, especially in hysterical women, or when there is involuntary micturition following emotional excitement, or when there is paralysis of the vesical sphincters, gelseminum is one of the few remedies that may relieve.

It has been said that 1- to 4-drop doses of gelseminum, repeated every three to four hours, will relieve the acute stage of gonorrhea. Aconite, however, will be preferable in most cases.

Gelseminum is a friend of the gynecologist and obstetrician. The more nervous the patient is, the more often the remedy will fit.

What will you do with a patient that is all excitement, having spasms, perhaps, and a "lump in the throat" that she cannot swallow, and then she complains about numbness of the extremities, tingling sensations, etc.? Give her gelseminum.

Or she is in labor, the excitement is great, the pains irregular, excruciating and tantalizing, the os rigid and progress very small on that account. There is danger of convulsions. Gel-

seminum will help. The same will take place if given for violent after-pains, with chilling and excitement.

And then there is dysmenorrhea, with its long and varied list of symptoms, such as spasmodic uterine or ovarian neuralgia, with cramps in legs or general twitching. "For sudden hysterical spasms, put 10 drops of the tincture or first dilution in half a glass of water and give a dessertspoonful every half-hour. It will cure about every case we are called to treat." (Burt.) Give the same remedy in hot water in those cases of menstrual pains where the flow is scanty and painful. Many cases have vertigo, faintness at the stomach and headache.

And then it is very useful in fevers, both of the enteric, intermittent, bilious or continued type. Many cases of the latter, that so much simulate typhoid fever, will yield to gelseminum and arsenicum, bryonia or podophyllum, according to symptoms. Those cases that are accompanied by great restlessness and excitement will be benefited at once by the administration of gelseminum.

Typhoid fevers, in which the nervous symptoms predominate, with great trembling of arms and legs, and occasional chilly sensations creeping over them, are well suited to gelseminum.

And then there are the eruptive fevers. When in measles or scarlet fever the eruption is slow in appearing, gelseminum will soon bring it out and also quiet the sensitiveness that so often is present in these cases.

In acute conditions gelseminum is best given in 1- to 5-drop doses of the tincture or 1 x. For chronic cases the higher potencies are best.

THERAPEUTIC HINTS.

BY W. C. ABBOTT, M.D., CHICAGO, ILL.

Addison's Disease.—The occasional occurrence of cases running many years shows that tubercle is not the only adrenal disease that causes this one.

Begin by making the alimentary canal absolutely clean and disinfect it; then take pains to keep it in proper condition throughout the case.

Whatever remedy is chosen, it is reasonable that long persistence can alone be expected to afford decided and permanent benefit.

The remedy is to be chosen after a careful study of the symptoms presented, and success can only follow correct therapeutic applications.

Iron arsenate has proved beneficial; in anemics, chronic forms, give gr. 1-67 every hour, except when the patient is asleep, for months.

The salts of manganese are apt to be best when the circulation is feeble and the volume of blood deficient; potassium permanganate, gr. 1-6, four times a day.

Phytolaccin may be of value when the lymphatics are clogged, the scrofulous type; gr. 1-6 to 1-2 before meals and at bedtime, for months.

Calcium lactophosphate is perhaps best for cases exhibiting cell-fragility and tendency to hemorrhages; gr. 1-6 every waking hour for six months.

The benefits from euophen reported are possibly due to its action as an intestinal antiseptic, or a stimulant of the absorbents.

Every remedy for anemia known has been used by the writer, the patients living ten years and more. Was this failure?

The only way we will ever succeed with incurable diseases is by pegging away, and never losing a possibility for lack of full trial.

We now recall cases in which we would now quickly saturate the patient with arsenic iodide and sustain it for weeks.

The persistent infiltration of minute doses of adrenalin into the system should give decided relief to the sufferer.

How about the persistent use of nuclein or of neuro-lecithin, for months, with weekly blood-examinations?

One other remedy for which we predict a notable future when it is studied is populin; analogous to, but not identical with, strychnine.

An ointment consisting of ung. iodi (U. S. P.) and lard, equal parts, is excellent in the treatment of frost-bites of the ears or digits, if the skin is unbroken. The slightly tender lumps that form under the chin and on the cheeks in cold weather require no treatment.

COLIC IN INFANTS.

Aethusa Cynapium.—Throws up its milk soon after nursing, with great force, suddenly; then falls asleep as if from exhaustion; awakens hungry.

Belladonna.—Child cries out suddenly and after awhile ceases as suddenly as it began.

Borax V.—Can not bear a downward motion, even if asleep.

Calcarea Carb.—Child is leuco-phlegmatic. Profuse perspiration about forehead and neck, and wets pillow when asleep; white chalk-like stools; much crying.

Chamomilla.—Irritable, fretful. Relief from motion, but begins crying as soon as motion ceases. Stools offensive, green or white and yellow mucus.

China.—Colic comes on at a certain hour every afternoon.

Colocynth.—Child writhes, doubles up, great pain; relieved by pressure on abdomen; ends with emission of much flatus.

Ipecacuanha.—Much nausea, clean tongue, fermented stools.

Jalapa.—Child is "good all day," but screams and is restless all night.

Lycopodium.—Always cries before passing water; is relieved immediately afterward; red sand or brick-dust deposit on diaper; much rumbling and rattling in abdomen.

Magnesia Carb.—Colic; relieved by a green liquid stool.

Mercurius.—Colic; relieved by a slimy, bloody stool, with straining.

Nux Vomica.—Colic, with constipation; frequent straining, with no result or a small, hard stool. Also diarrhea, stool small, with crying from pain before stool; much straining, with small stool and entire relief for a short time.

Pulsatilla.—Colic gets worse or comes on toward evening and lasts until after midnight. No two stools alike in color.

Rheum.—Much colic, with very sour-smelling stools.

Stannum.—Colic relieved by pressing firmly on abdomen.

Veratrum Album.—Colic, with coldness of forehead and feet; cold sweat on forehead. Give baby a teaspoonful or two of water several times a day.

Once a day, three or four ounces of warm water from nursing-bottle, with a little sugar of milk to flavor it, is helpful.

SELECTIONS.

EXAMINATION QUESTIONS AND ANSWERS MARYLAND
EXAMINING BOARD, JUNE 20-23, 1906.*Anatomy.*

1. Describe the upper extremity of the femur.

Answer.—It comprises a head, neck, greater trochanter and lesser trochanter. The head, directed upward, inward and forward, is hemispherical and coated with cartilage. It articulates with the acetabulum, and presents a small fossa at about the center of the articular surface for the ligamentum teres. The neck is a strong bar serving to join the head to the shaft at an angle of approximately 125 degrees. Its vertical diameter is greater than its thickness, and it is widest where it joins the shaft. Its junction with the shaft is marked anteriorly by a ridge which terminates above in the tubercle. Posteriorly the intertrochanteric ridge crosses the widest part of the neck. In front of the upper part of this line is the digital fossa. The trochanter major is a large cuboid process surmounting the shaft so as to overhang the digital fossa. Its outer surface is rounded and presents an oblique line passing from the upper back angle to the lower front angle. This process presents also an oblong anterior surface, a superior border, and a posterior border; the latter being the upper part of the intertrochanteric ridge. The trochanter minor is a prominent process situated at the back of the shaft about two and a half inches below the greater trochanter.

2. Describe briefly the elbow joint.

Answer.—The elbow joint is a typical hinge joint. The bony formation of the joint consists of the trochlea, of the humerus lying in the grasp of the sigmoid cavity of the ulna, together with the capitellum of the humerus resting in the cup on the head of the radius. The ligaments, as a whole, form a capsule, enveloping the joint, but studied separately they are: (1) The anterior ligament, lying in front and attached mainly above to the margin of the coronoid fossa and below to the margins of the coronoid process and orbicular ligament. (2) The posterior ligament is thin, passing from the upper margin of the olecranon

fossa downward to the olecranon. (3) The internal lateral ligament, fan-shaped, is attached by its upper narrow end to the internal condyle and by its lower broad end to the inner edge of the sigmoid cavity. (4) The external lateral ligament passes from the external condyle above downward to the orbicular ligament below. The synovial membrane lines the inside of the capsule and is reflected onto the articular surfaces. A pad of fat occupies the coronoid fossa and the olecranon fossa.

3. Name the accessory sinuses of the nose.

Answer.—(1) Maxillary, (2) Frontal, (3) Sphenoidal, (4) Ethmoidal, (5) Palatal.

4. Describe the collateral circulation after a ligation of the internal iliac artery.

Answer.—"By the anastomoses of the uterine and ovarian arteries (in the female); of the opposite vesical arteries; of the hemorrhoidal branches of the internal iliac with those from the inferior mesenteric; of the obtura artery; by means of its pubic branch, with other vessel of the opposite side and with the epigastric and internal circumflex; of the circumflex and perforating branches of the profunda femoris with the sciatic; of the gluteal with the posterior branches of the sacral arteries; of the ilio-lumbar with the last lumbar; of the lateral sacral with the middle sacral; and of the circumflex-iliac with the ilio-lumbar and gluteal."—Gray.

5. Name and give location of the salivary glands and state just where their ducts empty.

Answer.—The parotid glands are situated just behind the rami of the lower jaw, and their ducts (Stenson's) empty into the mouth opposite the second upper molar teeth. The sub-maxillary glands lie in the sub-maxillary triangles under cover of the angles of the jaw, and their ducts (Wharton's) open into the floor of the mouth on each side of the frenum of the tongue. The sub-lingual glands lie on the inner surface of the mandible just above the milohyoid ridges, and their ducts, several in number (ducts of Rivinus), open through the mucous membrane covering the glands.

6. Describe the portal system of veins.

Answer.—"The portal vein conveys blood from the stomach, from the whole of the intestine, except the terminal portion of

the rectum, and from the spleen and pancreas to the liver. Unlike other veins, it ends like an artery by breaking up into branches, which ultimately terminate in capillaries in the substance of the liver; from these portal capillaries the hepatic veins, which also receive the blood conveyed to the liver by the hepatic artery, arise; and as these open into the inferior vena cava, the portal blood ultimately reaches the general systemic circulation."—*Cunningham*.

Obstetrics and Gynecology.

1. Describe the preliminary arrangements and preparation for an approaching accouchement.

Answer.—Clean, well-heated, lighted, and ventilated room free from all dust, superfluous furniture and hangings, with a narrow bed or cot for confinement prepared with rubber sheet and draw sheet. Two pitchers for hot and cold sterile water, with three basins for washing and holding solutions, should be present; also douche pan, three dozen sterile pads, three binders for mother and clothes for baby. At beginning of labor patient should have general bath, especial care being given the genitals, and an enema. On near approach of delivery put to bed on Kelley pad or extra rubber sheet, wash genital region with soap water and antiseptics and clip hair. Cover surrounding regions with sterile towels.

2. What is your treatment for a case of placenta previa about the eighth month of pregnancy?

Answer.—If no hemorrhage is present and patient accessible, await onset of labor. Where there is hemorrhage or labor has begun, dilate and apply forceps or do a podalic version and bring down thighs as a plug, according to indications of individual case. If neither of these can be done, vagina may be tightly filled with gauze and allow presenting part to push it out.

3. Give diagnosis of a pregnancy at the third month.

Answer.—At this period absolute diagnosis is difficult or impossible. Symptoms are cessation of menstruation, nausea and vomiting, tingling in breasts, symptoms of pressure on bladder and rectum, nervous disturbances. Physical signs are softening and increase in size of cervix, lower uterine segment and whole uterus, which is fig shape and at top of symphysis; increased pigment in face, breasts, abdomen and vagina, increas-

ed vaginal secretion and size of breasts. From cancer or other tumor by history, consistency of uterus, lack of menstruation.

4. Describe the mechanism of a podalic version and mention the points of danger to the fetus.

Answer.—Pass the hand corresponding to the child's face into the uterus and grasp one or both feet, usually the anterior. Pull down on it and at the same time push the buttocks from the opposite side or the head upward with the free hand. Child may receive some injury, like fracture, from hand *in utero*, may be asphyxiated by pressure on cord in delivering after coming head, or have neck or other bones fractured in so doing.

5. Describe a complete abdominal hysterectomy.

Answer.—After sterilizing the hands, instruments and abdomen and anesthetizing patient, open abdomen in median line just above pubis by incising down to peritoneum and then raising and cutting peritoneum so as to avoid intestines. Ligate the ovarian arteries and place clamp on proximal sides of ligatures, cut between them, going down through broad ligaments nearly to uterine arteries. Incise peritoneum on anterior surface above bladder and push bladder off with gauze, ligate uterine arteries $\frac{1}{4}$ to $\frac{1}{2}$ inch from cervix so as to avoid ureters, carry broad ligament incision to vault of vagina proximal to ligatures. Cut around vaginal vault at junction with uterus and remove; stitch edges of vagina together or leave partly open if drainage is indicated. Stitch together edges of broad ligaments and peritoneum from bladder and pouch of Douglas. Mop peritoneum free from blood. Close wound with layer sutures, leaving in normal saline sutures.

6. Describe some condition of the uterus which may be relieved by an amputation of the cervix.

Answer.—Conditions of the cervix most helped by an amputation are great hypertrophy and elongation, especially where stenosed, and a much-lacerated one full of cicatricial tissue and much congested, or where cysts or chronic infection exists confined to cervix. Operation not sufficiently radical for malignancy.

Practice.

1. Define: (a) Tachycardia, (b) Leukemia, (c) Cretinism, (d) Hydrothorax, (e) *Ascaris Lumbricoides*.

Answer.—(a) Tachycardia (pulsus frequens) is an increased frequency in pulse rate, and may be constant or paroxysmal, physiologic or pathologic. (b) Leukemia is a disease characterized by a marked increase in the number of leukocytes in the blood, together with the enlargement and proliferation of the lymphoid tissue of the spleen, lymphatic glands and bone matter. Anemia, internal hemorrhage and increasing exhaustion are constant symptoms. (c) Cretinism is a congenital condition associated with absence or disease of the thyroid gland, and characterized by premature ossification of bones with deformity of head and face, stunted growth, mental dullness or idiocy. (d) Hydrothorax is an effusion of fluid in the pleural cavities. (e) *Ascaris Lumbricoides* is a common intestinal parasite inhabiting the small intestines and is generally known as the round worm.

2. Name symptoms of: (a) Ulcer of the Stomach, (b) Acute Nephritis, (c) Scarletina.

Answer.—In ulcer of the stomach there are various manifestations of indigestion. Paroxysmal pain localized in the pit of the stomach, or radiating from this point to limbs and back; aggravated by the taking of food, especially very hot, cold or spicy articles. Gnawing pain may be present between attacks of gastralgia. Localized tenderness (Boas' point) is very constant, and is usually elicited from one or two inches above pylorus. Vomiting is common, and if immediate, indicates ulcer near cardiac orifice. Pyloric ulcer gives rise to vomiting about one hour later. The vomitus contains undigested food and mucus, and is hyperacid. In hematemesis, which occurs in about 40 per cent of cases, the vomitus contains bright red blood or clots. The passage into intestines shows as dark stools. Enlargement in region of pylorus is infrequently demonstrated. Analysis of stomach contents shows increase in hydrochloric acid. Anorexia, anemia, loss of weight and strength are invariably present. (b) Acute Nephritis. The onset is rarely by a chill, but usually sudden, and characterized by dyspnea, sometimes by nausea and persistent vomiting. Fever is variable, ordinarily moderate. A full and tense pulse. Dull pain is experienced over kidneys, posteriorly, rarely referred along ureters. The desire to urinate is frequent, and the skin is harsh and dry. Dropsy appears early, and is first noticed in face and eyelids, ranging from a puffiness to general anasarca. Uremic symptoms may be added at any time; anemia

and weakness develops early. Urinary symptoms are most characteristic. The urine is scanty, smoky, of high specific gravity. Albumen is present in large quantities. The urea excreted is greatly lessened, as are also the phosphates and chlorides. Microscopically is found hyaline, blood, granular and epithelial casts. Uric acid, urates and oxalate crystals. Blood corpuscles and epithelium. (c) (Ordinary type.) Period of incubation varies; usually about four days. Begins abruptly, as a rule, rarely by a chill. Commonly vomiting, with convulsions in young. Fever rises rapidly, reaching 104° F. or 105° F. first day. Pulse range unduly rapid, one hundred and ten to one hundred and fifty. Pain in the throat and difficult swallowing. Bright scarlet rash appears at the end of twenty-four hours, visible first on neck and chest, spreads over body in course of several hours. The rash is uniform, not elevated, and disappears on pressure and there is no intervening healthy skin. Average duration of rash is from three to four days, and slowly disappears. Strawberry tongue is characteristic. Nervous symptoms mitigate or disappear when rash is established, and the temperature declines by lysis, reaching normal about the seventh day. Desquamation as scales and flakes begin at this period, and is rarely complete before the fifth week. Scanty albuminous urine is not uncommon. Intestinal symptoms not prominent.

3. What means would you employ in the diagnosis of diseases of the lungs, stomach, and kindeys?

Answer.—In diagnosing conditions of each, obtain a comprehensive history of the patient, including the family, his past and present. And in diseases of the lungs, employ inspection, palpation, percussion, auscultation, mensuration and succussion. If obtainable, examine microscopically and macroscopically sputa and exudates. In examinations of the stomach employ inspection, palpation, percussion, auscultation and succussion. Inflate and determine size and position of organ. Administer test meal and examine contents of stomach. Ascertain the motor and absorptive power and examine bacteriologically. In diagnosing kidney disease, employ inspection, palpation, percussion and auscultation. Secure specimen by catheterism of bladder or ureters, if necessary, and examine. Determine twenty-four hours quantity, color, odor, consistency, specific gravity, reaction, total urinary solids; examine for albumen, sugar, blood, bile-pigment (sudi-

can), acetone, diascetic acid, oxybutyric acid, fat and pus. Microscopically for casts, organisms, etc.; also verify certain substances found macroscopically and chemically.

4. Name some of the sequelæ of typhoid fever. Name some causes of intestinal obstruction.

Answer.—The sequelæ of typhoid fever are manifold, as persistent diarrhea, lobar pneumonia, bronchitis, pleuritis, ulceration of larynx and laryngeal paralysis, endo- and peri-carditis, thrombosis of veins, gangrene of feet and legs, pharyngitis, suppurative proctitis, cholecystitis, gall-stones, neuritis, post-typhoid insanity, paralysis, arthritis, nephritis, conjunctivitis, otitis, decubitus, bone necrosis and various skin lesions. Briefly stated, the causes of intestinal obstruction are strangulation, intussusception, volvulus, fecal impaction, enteroliths, gall-stones, tumors, strictures, intestinal paralysis and abnormal contents.

5. Give treatment of diabetes mellitus and of laryngeal diphtheria.

Answer.—Interdict or reduce to minimum the starches and sugars. Allow non-carbohydrates. Use saccharin or glycerine in lieu of sugar when latter is demanded. Ventilation, fresh air, daily bathing, appropriate exercise and attention to secretions are essential. Fatigue and exposure avoid. Medicinal treatment is unsatisfactory, as no drugs recommended have a direct curative influence. Opium is a remedy capable of limiting the progress of the disease. It should be given in increasing doses until sugar is reduced to a minimum, and then gradually withdrawn. Next to opium, codeine probably deserves the most confidence. Many drugs, such as bromide of arsenic, the salicylates, nitroglycerine, potassium iodide, lactic acid, adrenalin. Fair doses of the coal tar products, notably antipyrine and the preparations of the pancreas, are recommended. Chloral and the bromides are useful adjuncts, and benefit nervous symptoms. The various skin lesions should receive appropriate treatment. Coma is an almost hopeless complication, and requires inhalation of oxygen, hypodermoclysis and enteroclysis, alkalies are esteemed as preventives. Stimulate. (b) When the larynx becomes involved in a case of ordinary diphtheria, the following additional measures are advisable: A steam tent may be arranged so that the patient may breathe an atmosphere saturated with moisture. The vapor

of slaking lime, and lime water with glycerine is a suitable remedy. If dyspepsia becomes urgent, prompt-acting emetics should be administered. When suffocation is threatened from the laryngeal obstruction, intubation or tracheotomy should be immediately performed. Antitoxin should be given heroically. Bold stimulation.

Give diagnosis and treatment of tetanus.

Answer.—Trauma or wound antedate the onset. Infrequently begins abruptly, commonly by headache and chilliness with stiffness of the neck. Tonic spasm of the masseters (lock-jaw) develops early. Head is drawn back and legs extended, and the body is thrown into general spasm. The arms, however, are little involved. Spasms are excessively painful, and recur spontaneously, and result from external irritants. The muscles remain tonically contracted during intervals. Febrile reaction is variable. *Treatment.*—It is imperative that the patient be confined to bed in a quiet, darkened room. Scrupulously prohibit all source of irritation and excitement. Incise and antisepticize the wound. The spasms will require the inhalation of chloroform or nitrite of amyl, and the administration of such drugs as chloral, morphine, codeine, bromide of potash, antipyrine, belladonna, etc. Use antitoxin of tetanus. Maintain nutrition by rectal alimentation, or feed through nose with catheter. Liberal stimulation when advisable.—*State Board Journal of America.*

Acalypha Indica is said to be a specific for hemorrhage from the lungs or throat. Use 6 x dilution, 10 drops in one-half glass of water, and take a teaspoonful every half-hour until it stops.

Calcarea carb. will antidote any bad effects produced by the *acalypha Indica*.

Acalypha Indica hemorrhage comes on in the morning with bright red blood, not profuse; becomes dark and clotted in the afternoon. Violent cough in paroxysms at night; patient has a played-out feeling in the morning, and gains strength as the day advances.

THE MEDICAL FORUM.

A Monthly Journal Devoted to the Interest of the Homœopathic Profession.

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EDITORIAL.

HOMEOPATHIC TEXT-BOOKS IN HOMEOPATHIC COLLEGES.

In a somewhat peculiar manner the question of homeopathic text-books has been brought to the writer's attention from two opposite sides. There was a good friend of ours, a zealous homeopath, who earnestly protested against the use of any but homeopathic text-books in our medical colleges; and there was the editor of the official organ of the dominant school in Texas, who had compiled a list of text-books used in various schools—allopathic, homeopathic and eclectic. The fact stood plainly forth that the great bulk of all text-books used were written by members of the regular school. The argument drawn from this fact was that, as most of the teaching received is based on text-books adopted by all schools, therefore one board of medical examiners should suffice.

What are the facts in the case? It is plain that no homeopathic college could teach a complete medical course without using text-books not written by homeopaths. Those who are best acquainted with our literature know that this is simply a statement of the plain unvarnished truth. Truth stands, whether we like it or not.

What does this fact mean? Does it prove that the members of the opposing school are more learned, have greater ability, and are therefore masters of the situation? Are homeopaths intellectually inferior to their professional brethren known as the "old school"? No! emphatically no!

But why this condition? An explanation is easy.

1. There is no difference between schools of medicine pertaining to the purely scientific branches of our professional teaching. Only in materia medica and therapeutics do we disagree. Therefore we need no homeopathic anatomy, physiology, pathology, etc.

2. Whenever there are new fields opened, new countries settled, new schools started, it takes a long time to get over the primitive period. Homeopathy was something new. There was a long and bitter controversy about its teaching, which is not at an end yet. The result of that has been, that our literature has been developed mostly along that line. No school has such a complete and extensive materia medica as we. Nowhere can therapeutical indications for remedies be found as much developed as in the text-books of our school. We were and are busy developing our specialty and fighting for our rights; therefore, we have not written text-books on subjects that are already well treated, but have rather accepted the good work of others.

3. The violent and unjust opposition against homeopaths has effective in this respect. In order to write books of value on scientific subjects, there is required opportunity and leisure. Such the busy practitioner has not. And it is a fact that the powers that be have excluded homeopaths from such positions that afford the required conditions for such work. That has made it a matter of wisdom not to attempt a work that could not be carried out satisfactorily.

4. This same opposition would make every such undertaking a financial failure. Suppose a homeopath would take an excellent manuscript on any one of the subjects in question to

one of the large publishing houses; would they publish it as they would if it came from an "old school" writer? Indeed they would not. Why? Because, if the authorship were known, the book would find only a very limited market.

Homeopaths have always justly complained of being unfairly treated in this respect. If they advance a theory, it is laughed at, even if later it must be admitted as proven. Before that is done, however, they will twist it a little and clothe it in a different garb. Dr. Pratt devised a rectal speculum that is the peer of all that are made, and yet the writer examined a "standard" work on rectal diseases a few days ago, and found illustrations of various inferior specula, but none of Pratt's. Give us a chance and treat us justly, and we will show you a few things.

5. And lastly, let us come nearer home. Our complaint against members of other schools; it's only stating a fact, but many things would be different if the thousands of doctors composing the homeopathic branch of the profession were more consistent and would buy more of our publications. As it is, we fear that only a few would buy a homeopathic text-book on pathology, for only a few bought the text-books heretofore published on other subjects. Homeopathic books have been high in price, had fewer costly illustrations, because of the limited sale expected. How many writers of excellent works had all the experience they wanted in trying to dispose of the product of their brain and pen? When we once lay aside our apathy, and buy the books that are now on the market, others will be published, and then the time may come when a homeopathic college can make out a list of text-books that are homeopathic. Till that time comes, they must do as they have been doing in the past.

EFFICIENCY AND COMMERCIALISM.

The medical profession should be free from commercialism, if such a thing is possible. His main study should be to heal the sick. He should do this in the shortest time possible. His chief study should be to become proficient in the art of healing, in order to do the greatest amount of good. Efficiency should be the watchword of the profession.

It is to be regretted that the desire to "make money" has dragged many away from the pursuit of lofty ideals, so that now all they do is made to serve this end. Diagnosis, prognosis and prescription must serve this purpose. The dollar is the prime object; the effort to cure is made to make money.

In all things we should apply the Golden Rule. We would hesitate to place our life chances into the hands of a man possessed of the spirit of commercialism. We would fear that he would not give us that unselfish advice and attention we think we ought to have. Whether we realize it or not, this feeling is out among the people. They hate an unsympathetic, grasping, selfish doctor. They will seek the advice of one in whose integrity they have confidence. Selfishness and commercialism act as a boomerang. It strikes the selfish man harder than anyone else.

The doctors should have reasonable compensation for all services rendered; but they have no right to charge fancy prices "for an operation" or medical services. It is a discredit to all who are engaged in the practice of our profession. It will be a happy day when our professional brethren will adopt the motto: "Efficiency first, remuneration next."

HAHNEMANN POST-GRADUATE COURSE.

The physicians of Kansas, Missouri, Nebraska and adjoining States are invited to attend the post-graduate course to be given by the faculty of Kansas City Hahnemann Medical College, beginning Monday, April 15, at the college, 1020 East Tenth Street. The course will last one week, and if those attending so desire, it will be extended a few days longer. Owing to the excellent clinical advantages which the college enjoys, there will be excellent opportunity to brush up on any particular line which the physician wants. The surgical clinics will be very complete. Besides demonstrations at the college and private operations at the hospitals, a whole day will be devoted to a clinic at the General Hospital, where a large number of major operations especially selected will be performed. The new spinal analgesia will be demonstrated. In the chairs of eye, ear, nose and throat, nervous and mental diseases, gynecology, genito-urinary and venereal, dermatology, bacteriology, children's diseases, materia medica and diseases of the stomach, men of recognized ability in their particular lines will have charge. The course will be a practical one and of value to the general practitioner.

This course is offered to the profession free of charge, in the hope that a larger number of physicians will become better acquainted with Hahnemann College. The Missouri State Board of Health recently stated in a bulletin that this college was second in the State in point of teaching facilities and equipment, in spite of the fact that there are eleven medical colleges in the State.

The arrangement of the course is in charge of the Registrar, Dr. G. W. Smith, 407 Deardorff Building. A list of the faculty of the college will be seen on the inner side of the front cover of this issue of the Medical Forum. Any physician desiring to take up a particular line of work can do so by writing to the Registrar or to the professor of the chair. Remember the date, April 15; the place, 1020 East Tenth Street.

NEWS NOTES AND PERSONALS.

Send any news items or personals to the Local Editor of the Medical Forum, Dr. Maclay Lyon, 409 Deardorff Bldg.

Commencement exercises of Kansas City Hahnemann occur April 15.

The Kansas City Hahnemann post-graduate course begins April 15.

Dr. W. A. Bonniwell, of Kansas City, has moved his office to 1209 Grand Avenue.

Dr. S. D. E. Woods, of Wilsey, Kansas, was a visitor in Kansas City the latter part of February.

Don't forget the meetings of the Missouri Institute of Homeopathy to be held at Kansas City, April 23-24-25.

Dr. W. E. Reily, of Fulton, Mo., lectured to the students of Kansas City Hahnemann early this month at the General Hospital on clinic day.

Dr. A. W. Cormack, of Fredonia, Kansas, brought a case for operation to Kansas City recently and incidentally subscribed for the Medical Forum.

To Practitioners.—Don't forget the post-graduate course given by Kansas City Hahnemann, April 15 to 21. See announcement elsewhere in this issue.

Dr. Jas. T. Davis, Kansas City Hahnemann '06, has located his office at 320 Missouri Building, Kansas City, Mo. His residence is at 908 Park Avenue.

Mrs. A. F. Higgins, wife of Dr. Higgins, of Emporia, died suddenly at her home, March 8. Dr. and Mrs. W. A. Forster, of Kansas City, attended the funeral services at Emporia, March 10.

Dr. O. L. Garlinghouse, of Iola, purchased a motor car in Kansas City at the show which closed March 10.

The New York Skin and Cancer Hospital will have free lectures to the profession, by Dr. L. Duncan Bulkley, March 27 and April 3, 10 and 17. Dr. Wm. Seaman Bainbridge will lecture April 24.

Dr. C. E. Allen, of Kansas City, has recently installed one of those cabinets in which various vile-smelling nostrums are sprayed for inhalation, and the other doctors in the building are threatening to move out. It surely "smells to heaven."

It seems as if it were about time for Dr. Reily to revise his homeopathic directory of Missouri and neighboring States. If for no other reason, it is needed to correct the errors of the latest issue of Polk's Medical Directory, issued last summer.

Dr. Jay B. Smythe, of Holton, Kansas, was in Kansas City a few days ago, attending the Automobile Show in Convention Hall. The doctor is one who makes practical use of the "devil wagons." He uses a four-cylinder Smith car and covers a large territory with it.

There has been an alarming epidemic of measles in the two Kansas Cities. In less than four weeks there were reported in Kansas City, Kas., over two hundred cases and two deaths. In Kansas City, Mo., there was on an average of five cases a day reported for several days.

The Missouri State Board of Health in a recent bulletin declared that Kansas City Hahnemann was, in point of teaching and clinical equipment, second in Missouri. This is good news, inasmuch as there are in the State eleven medical colleges, of which two are homeopathic.

There is an excellent opportunity for an homeopathic physician at Hammond, Indiana. The town now has 20,000 population and will grow rapidly on account of the new steel plant which will be built there. Information will be given by Dr. Maclay Lyon, 409 Deardorff Building, Kansas City.

Dr. Clay E. Coburn, of Kansas City, Kas., has been appointed by Governor Hoch a member of the State Board of Health. He succeeds Dr. Ernest F. Mills, of Olathe, who has gone to Ogden, Utah, to live. Dr. Coburn was the unanimous choice of the nominating committee of the Kansas State Society.

The date for the annual meeting of the Kansas State Homeopathic Medical Society has been fixed for May 9, 10 and 11, at Topeka. Heretofore there has been a conflict in dates with the Nebraska meeting. Dr. Addison Kendall, of Great Bend, is president, and Dr. May Stout, of Topeka, secretary.

Dr. Daniel W. Miller, Kansas City Hahnemann '01, eye and ear specialist, of Blackwell, Okla., was in Kansas City recently and visited with old friends. He also became a subscriber of the Medical Forum. The doctor's practice is increasing and he is one of the well-known specialists in that section of the country.

State Chemist E. H. S. Bailey, of Kansas, recently discovered that blue vitriol was being used in oysters to preserve them. Ach der lieber! What next?

Dr. Edith A. Emmet, of Kansas City, died January 18, at her home, after a lingering illness. She was a graduate of Kansas City Homeopathic, class of '83.

Dr. Ernest F. Mills, who has been in practice in Olathe, Kansas, for the past several years, has decided to locate in Ogden, Utah. Dr. Mills has held several offices of importance in Kansas, having been a member of the State Board of Health for the past two years, was president of the Kansas State Homeopathic Medical Society and was county physician and coroner at Olathe. For several years he taught in Kansas City Hahnemann, where he held the chair of materia medica as professor.

The Bureau of Diagnosis of the Missouri Institute of Homeopathy, to be held at Kansas City, April 23-24-25, has been arranged as follows: "Intestinal Obstruction," W. A. Forster, Kansas City; "Modern Methods of Diagnosis," J. H. McCaughan, M.D., St. Louis; "Some Differentiations," G. W. Smith, M.D., Kansas City; "Just a Diagnosis," G. F. Adams, M.D., Kenosha, Wis.; "Relationship of Diagnosis to the Remedy," L. P. Crutcher, M.D., Kansas City; "A Diagnosis," C. J. Luyties, M.D., St. Louis; "Neoplasms," Charles Ott, M.D., Kansas City; "Stomach Mistakes," Maclay Lyon, M.D., Kansas City.

The following resolution was adopted by the Faculty of Kansas City Hahnemann at its meeting March 11, 1907, relative to the death of Dr. E. H. Merwin, who was professor of surgery:

"Resolved, By the Faculty of Kansas City Hahnemann Medical College in session March 11, 1907, that in the death of Dr. E. H. Merwin the college lost one of its most faithful professors, and that the loss is felt keenly by the members, both professionally and personally.

"Dr. Maclay Lyon,
"Dr. J. L. Alexander,
"Committee."

Here is a chance to get a medical license in Oklahoma. The following are secretaries of examining boards and their locations: Dr. Le Roy Lorry, South McAlester; Dr. B. F. Fortney, Vinita; Dr. W. L. Peters, Chickasha; Dr. J. B. Smith, Durant; Dr. M. F. Williams, Muskogee. Graduates of reputable medical colleges can get license to practice by sending their diplomas and \$1 to the secretary of above list who is nearest the place in which applicant desires to practice. The State board meets the first Monday in January, April, July and October. After Oklahoma is admitted to statehood, an examination will be required of all applicants. There are several excellent locations in Oklahoma for homeopathic physicians. Information regarding these can be obtained by writing to Dr. D. W. Miller, Blackwell, Oklahoma.

Dr. Leonard R. Booth, who is a railroad contract surgeon in Wyoming, was called to Kansas City this month by the death of an uncle. Dr. Booth is a graduate of Kansas City Hahnemann, class of 1901. He will inherit something like \$25,000 from the estate.

The Nebraska State Homeopathic Medical Society will meet at the Lindell Hotel, Lincoln, Nebraska, May 21, 22 and 23. The officers of the society are: president, E. Arthur Carr, M.D., Lincoln; first vice-president, H. R. Miner, M.D., Falls City; second vice-president, F. A. Marsh, M.D., Seward; corresponding secretary, F. F. Teal, M.D., Omaha; recording secretary, F. S. Whitman, M.D., Omaha; treasurer, O. S. Wood, M.D., Omaha. The prospects for the meeting are fine. An attractive program is being prepared.

President George A. Mellies, of the Missouri Institute of Homeopathy, in a letter relative to the forthcoming meeting of the Institute at Kansas City, April 23, 24 and 25, has this to say to the profession: "I wish to call attention to the thirty-first annual session, which should make a new epoch in Missouri Institute work. With the advancement of the science of medicine come new questions for consideration and study, and it is incumbent on every physician who is an adherent to the system of medical practice which has stood the test of a century, or tentatively adopts its principles in his daily practice, to take part in this meeting, by being present and, if not presenting a paper, participating in the discussions. Every physician who attends enhances his reputation and professional standing in his community, and he himself becomes a broader man and better qualified in the pursuit of his chosen profession."

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Hahnemann Monument, J. H. McClelland, M.D., Pittsburg, Pennsylvania.

Vaccination, A. M. Linn, M.D., Des Moines, Iowa.

Intercollegiate, N. B. Delamater, M.D., Chicago.

Conference with the International Homeopathic Association and the Ophthalmological, Otological and Laryngological Society, J. M. Lee, M.D., Rochester.

Formation of National Association for Clinical Research, Walter Wesselhoeft, M.D., Cambridge, Mass.

Subscription for Hahnemann Hospital and College of San Francisco, Cal., J. C. Wood, M.D., Cleveland, Ohio.

Bureaux.

Materia Medica and Therapeutics, V. H. Hallman, M.D., Hot Springs, Ark.

Homeopathy, Wm. Boericke, M.D., San Francisco, Cal.

Clinical Medicine and Pathology, C. E. Sawyer, M.D., Marion, Ohio.

Pedology, H. H. Baker, M.D., Chicago.

Sanitary Science and Public Health, E. H. Porter, M.D., New York.

Sectional Societies.

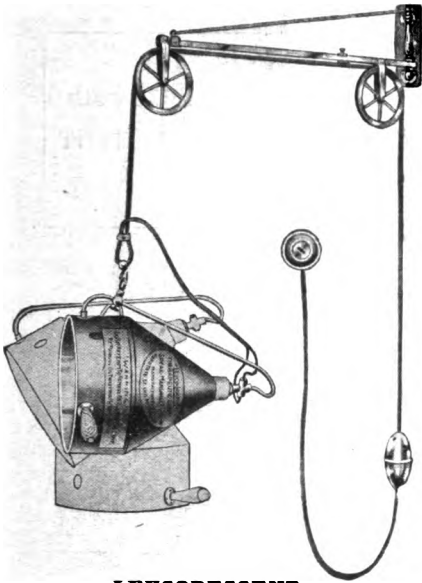
Surgical and Gynecological, Pres. Horace Packard, M.D., Boston, Mass.

Ophthalmological, Otological and Laryngological, Pres. E. L. Mann, M.D., St. Paul, Minn.

Obstetrical, Pres. Florence N. Ward, M.D., San Francisco, California.

National Society for Physical Therapeutics, Pres. Hills Cole, M.D., New York.

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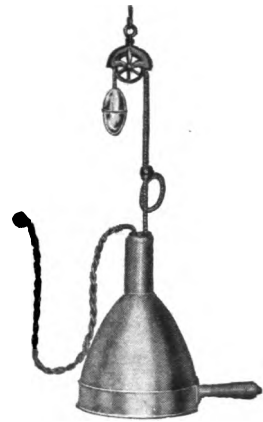
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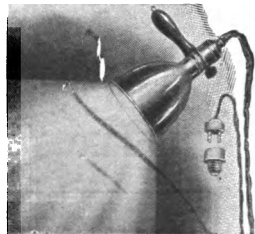
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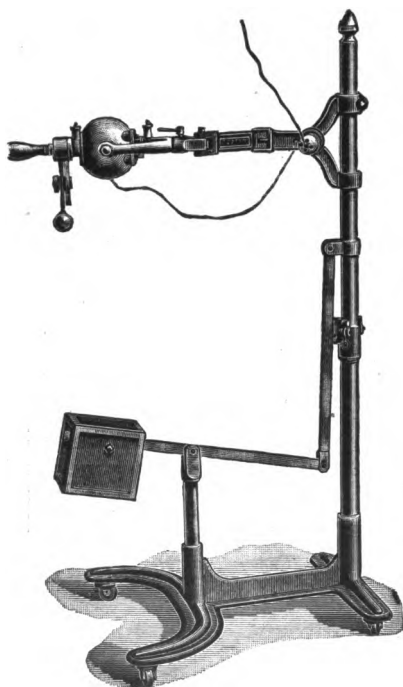
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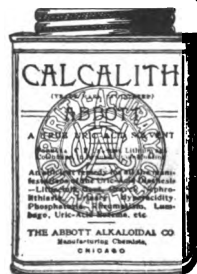
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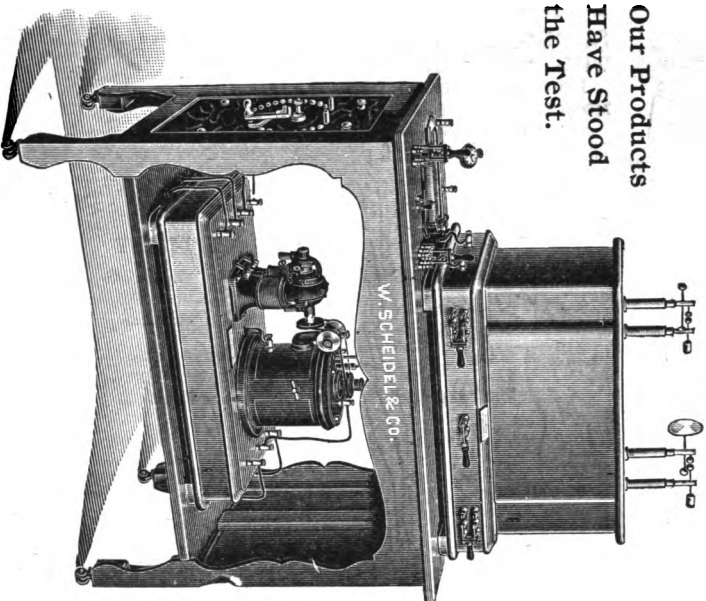
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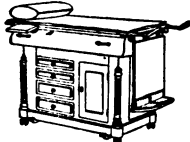


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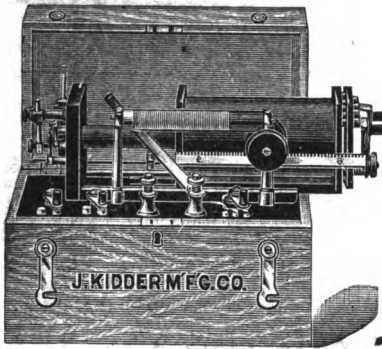
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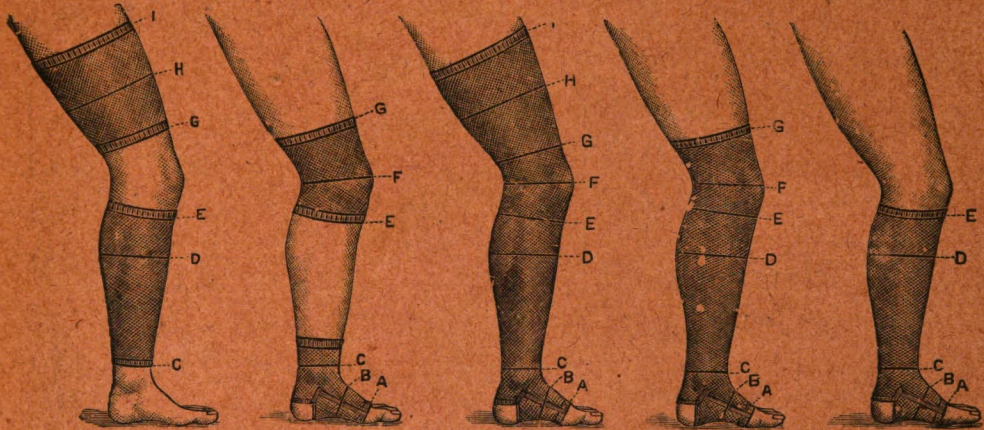
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